

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-046810

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

380

Primary Registration District No.

6225

Registrar's No.

177

FILED DEC 3 1963

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>McDonald</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Nevada</u>		c. CITY OR TOWN <u>Powell</u>	
Length of stay in 1b <u>6 Mo. 23 Days</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital # 3</u>		d. STREET ADDRESS (If outside, give location) <u>Powell</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert O. McCary</u>		4. DATE OF DEATH Month Day Year <u>11 16 1963</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-5-1881</u>
9. AGE (last birthday) <u>81</u>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (City and state or country) <u>Exeter, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Azberry McCary</u>		13b. MOTHER'S MAIDEN NAME <u>Molly Horner</u>	
14. NAME OF HUSBAND OR WIFE <u>Dollie McCary</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>[REDACTED]</u>		17. INFORMANT <u>Hospital Records Nevada, Missouri</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u> Years _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>APRIL 23- '63</u> to <u>NOV. 16. '63</u> and last saw her alive on <u>NOV. 15- '63</u> Death occurred at <u>9:15 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Glinda Mayfield M.D.</u>		22b. ADDRESS <u>State Hosp. Nevada Mo</u>	
22c. DATE SIGNED <u>11-16-63</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
23b. DATE <u>11/16/63</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Masadonia Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Stella, Missouri</u>		24. FUNERAL DIRECTOR ADDRESS <u>Sisco Funeral Home Pea Ridge, Arkansas</u>	
25. DATE RECD. BY LOCAL REG. <u>11-25-1963</u>		26. REGISTRAR'S SIGNATURE <u>Arma J. Perry</u>	

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

*Percy F. Milster*

Licensed Embalmer No. \_\_\_\_\_

*4805*

P. O. Address \_\_\_\_\_

*Nevada, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.